



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF FORT WORTH
3255 W PIONEERY PKWY
ARLINGTON TX 76013

Respondent Name

City of Fort Worth

Carrier's Austin Representative Box

Box Number 04

MFDR Tracking Number

M4-12-1055-01

MFDR Date Received

December 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...per ASC RULE 134:402: Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: \$195.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is an add on code. Need to bill primary procedure code. 96360. Per NCCI edits, the values are included in the value of the comprehensive procedure, 70553. Need modifier – 59."

Response Submitted by: CCS Holdings, P.O. Box 541387, Dallas, TX 75354

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2011	Outpatient Hospital Services	\$195.36	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 28, 2011

- 25 – SIGNIFICANT E/M
- 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B)

PLUS THE TEXAS MARKUP.

- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 446 – THE ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.
- 616 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.

Explanation of benefits dated October 21, 2011

- 236 – THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE.
- 351 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 446 – THE ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- B15 – THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.
- W1 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

ISSUES

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for

Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75

- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.91. 125% of this amount is \$14.89
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.68
- Per Medicare policy, procedure code 96361 may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 96374 may not be reported with procedure code 70553 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 96375 may not be reported with procedure code 70553 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 96376 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.55. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$127.69. The non-labor related portion is 40% of the APC rate or \$89.03. The sum of the labor and non-labor related amounts is \$216.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$216.72. This amount multiplied by 200% yields a MAR of \$433.44.
- Procedure code 70553 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8008; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0337, which, per OPPS Addendum A, has a payment rate of \$533.60. This amount multiplied by 60% yields an unadjusted labor-related amount of \$320.16. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$306.10. The non-labor related portion is 40% of the APC rate or \$213.44. The sum of the labor and non-labor related amounts is \$519.54. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$519.54. This amount multiplied by 200% yields a MAR of \$1,039.08.
- Procedure code A9579 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0780 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is \$1,504.84. This amount less the amount previously paid by the insurance carrier of \$1,504.84 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	_____ May 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.